State of California Department of Consumer Affairs

Board of Optometry
400 R Street, Suite, 4090, Sacramento, CA. 95814
Tel: (916) 323-8720
www.optometry.ca.gov

GLAUCOMA PATIENTS COLLABORATIVE TREATMENT COMPLETION FORM

Pursuant to Business and Professions Code section 3041(f)(2), this form serves as documentation to the board that the California licensed optometrist herein listed has completed - with an ophthalmologist - all or a portion of the collaborative treatment of 50 glaucoma patients over 18-years-old. The patients shall each have been collaboratively treated for the required two-year period. The listed optometrist must first complete a didactic course developed by a California school/college of optometry of not less than 24 hours before beginning collaborative patient treatment unless the optometrist graduated from an accredited California school/college of optometry after May 1, 2000.

This form shall be used by each individual collaborating ophthalmologist in documenting patient(s) treatment in adherence with the optometrist's developed treatment plan as approved by the ophthalmologist prior to treatment and specified in subsection (f)(2)(A) of the above referenced code section. The ophthalmologist shall list below the first name and last name initial of the patient, dates he/she confirmed the optometrist's glaucoma diagnosis, performed a physical examination of the patient, written approval of treatment plan, annual achievement of goals and his/her documenting initials.

	First Name Last Initial	Diagnosis Confirmed	Physical Exam	Approval: Treatment	Annual Goals	Collaborating MD's Initials
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GLAUCOMA PATIENTS COLLABORATIVE TREATMENT COMPLETION FORM CONTINUED

	First Name Last Initial	Diagnosis Confirmed	Physical Exam	Approval: Treatment	Annual Goals	Collaborating MD's Initials
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Both the California licensed optometrist and collaborating ophthalmologist shall sign below and provide their printed names and state license numbers where appropriate.

I declare under penalty of perjury under the laws of the State of California that the information provided on this form is true and I understand and agree that any misstatements of material facts may be cause for denial of the licensed optometrist's certificate to treat open angle glaucoma and disciplinary action by the board.

Signed: _____ **Signed:** _____
(Optometrist) **(Ophthalmologist)**

Date: _____ **Date:** _____

Print Name: _____ **Print Name:** _____

CA License #: _____ **State (Designate) License #:** _____